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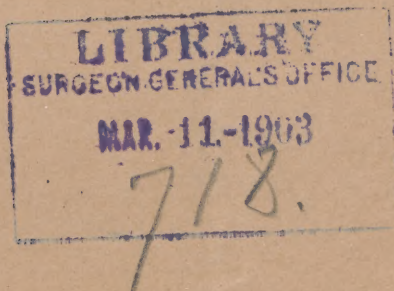
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A RELIABLE TECHNIQUE FOR THE REPAIR OF COMPLETE LACERATIONS OF THE PERINEUM.

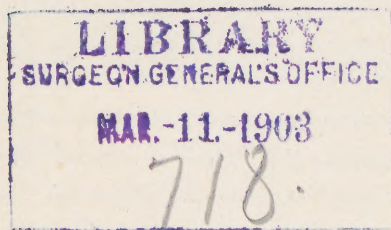
BY BARTON COOKE HIRST, M.D.,

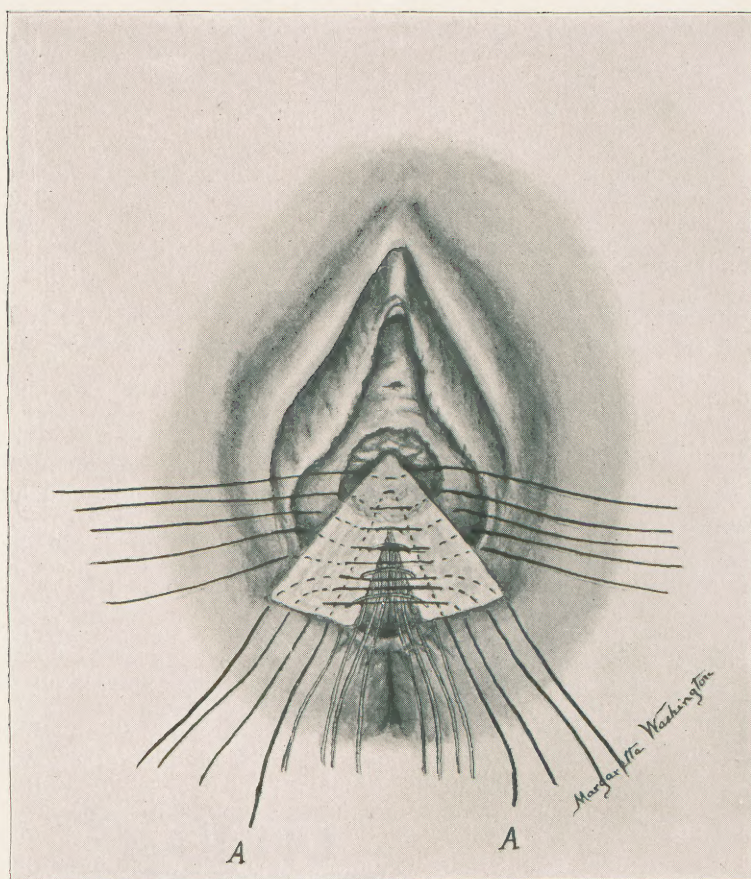
PHILADELPHIA,

Professor of Obstetrics, University of Pennsylvania.



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The sutures for a complete laceration of the perineum in either a primary or secondary operation. *A, A*, the barrier or splint stitch.

A RELIABLE TECHNIQUE FOR THE REPAIR OF COMPLETE LACERATIONS OF THE PERINEUM.

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EVERY year for several years past the writer has had two or three, sometimes four, operations for complete lacerations of the perineum in cases operated on by others without success, besides his own cases in consultation of primary and secondary repair of tears through the sphincter. It appears, therefore, that the technique of these operations is not as thoroughly understood as it might be, or as if the surgeons who fail to secure uniformly good results, some of them expert gynecologists, would do well to adopt a plan of operating that could be depended upon in every case. For ten years the writer has employed a method which has not failed in a single instance, as far as he knows, to restore the sphincter perfectly without a recto-vaginal or a recto-perineal fistula. The illustration shows the method of introducing the sutures, four of which are usually knotted in the rectum. Above the rectal sutures a triangular stitch is inserted somewhat resembling the Emmet suture for securing the ends of the sphincter, but placed above the sphincter, which is brought together by the rectal stitches, and acting simply as a splint to the rectal wound, an additional support to the sphincter stitches and a barrier between the rectal and vaginal sutures. The vaginal wound is united by vaginal and perineal sutures, as in the Hegar operation for lacerated perineum. This mode of suturing is much superior to the Emmet operation for complete lacerations. The latter, indeed, has given, in the writer's experience, a larger proportion of failures than almost any other plan. This was also the experience of the late Dr. Goodell. In a very ex-

tensive denudation it is often an advantage to whip the whole denuded surface together by a two-tier running catgut suture, beginning in the upper angle of the vaginal denudation, running down the deeper part of the wound, just short of the rectal mucous membrane, and returning in the vagina to a point opposite the original insertion, so that the two ends are joined by a single knot. Naturally, the catgut suture must be inserted after the interrupted silkworm-gut sutures are all in place. The latter are knotted in the rectum, shotted in the vagina and perineum. If the catgut supplementary stitch is not employed, it is convenient to tie the rectal stitches from above downward in regular order, then to shot the triangular splint stitch, converting the case into one of a simple Hegar operation for lacerated perineum. The vaginal and perineal sutures are inserted after the rectal and splint stitches have been fastened.

There are certain principles essential to success in all operations for complete tears which must not be neglected in the operation just described. The bowels must be thoroughly emptied and carefully irrigated before the operation, so that there shall be no evacuation of feces to embarrass the operator and to infect the wound. The sphincter muscle should be stretched; the denudation must be extensive and must be carried so low that there is no possibility of missing the ends of the sphincter. It would cause surprise were the writer to enumerate the operators who have failed on this point. The two lowest rectal stitches which catch the sphincter ends must take the deepest possible bite, and before joining them several cross cuts with a knife or scissors should be made upon the ends of the muscles to lay bare their fibres. As a test whether the muscle is caught by the stitches or not, two tenacula should be hooked into the tissues between the stitches and pulled upon. If they have the ends of the muscle in their grip, it may be made to play between them under the skin of the anus.

In the after-treatment of the patient a choice should be made between two procedures: either to keep the bowels fluid and moving from the first or to lock them up for two weeks. The former is much the better plan and is adopted by the writer almost invariably. Two or three glasses of Carlsbad water with a teaspoonful of Sprudel salts daily secures the desired result—about three liquid stools a day—without irritating the alimentary tract. The diet should be strictly liquid.

There are some obstinately constipated patients, however, in whom a quantity of purgative medicine is required so excessive that the stomach and bowels rebel. This point should be tested by a purgative course for several days before the operation. If it is found that the woman probably will not bear for two weeks or more the amount of purgative medicine required to produce three liquid stools a day, she should be given after the operation a half grain of opium extract twice daily, her diet should be rigidly restricted to skimmed milk, clear soup, and a little tea, and her bowels should be kept unmoved for fourteen to sixteen days. Then the operator himself should inject the rectum with a solution of ox-gall and with sweet oil and should irrigate the bowel; a course of calomel, followed by elaterium, should be administered, so that the bowels shall be thoroughly evacuated before the stitches are removed.

In removing the rectal stitches it is convenient to place the woman in the knee-chest posture and to expose the suture knots with a very small rectal speculum, illuminated by an electric head-light.

